ARC 5362C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to uniform prior authorization process

The Human Services Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4 and 2019 Iowa Acts, House File 766.

Purpose and Summary

2019 Iowa Acts, House File 766, required implementation of a uniform process to request medical prior authorization under the Medicaid program. As a result of implementing the uniform prior authorization process, there has been a change in forms and form numbers used to request a prior authorization. These amendments align the rules with the new forms and processing time frames. The rules are also revised to update outdated sections with current practices and processes.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on October 21, 2020, as **ARC 5229C**. No public comments were received. No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on December 10, 2020.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on March 1, 2021.

The following rule-making actions are adopted:

ITEM 1. Amend paragraph **78.10(1)"c"** as follows:

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made ~~on Form 470-0829, Request for Prior Authorization~~ using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

ITEM 2. Amend paragraph **78.10(2)"b"** as follows:

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. ~~See 78.10(5)*"d"* for prior authorization requirements.~~
Bathtub/shower chair, bench. See 78.10(5)*"g"* and *"j"* for prior authorization requirements.
Commode, shower commode chair. See 78.10(5)*"j"* for prior authorization requirements.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(5)*"a"* for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Heat/cold application device.
Hospital bed and accessories.
Inhalation equipment. See 78.10(5)*"c"* for prior authorization requirements.
Insulin infusion pump. See 78.10(5)*"b"* and 78.10(5)*"e"* for prior authorization requirements.
Lymphedema pump.
Mobility device and accessories. See 78.10(5)*"i"* for prior authorization requirements.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift. See 78.10(5)*"h"* for prior authorization requirements.
Phototherapy bilirubin light.
Protective helmet.
Seat lift chair.
Speech generating device. See 78.10(5)*"f"* for prior authorization requirements.
Traction equipment.
Ventilator.

ITEM 3. Rescind and reserve paragraph **78.10(5)"d."**

ITEM 4. Amend paragraph **78.10(5)"e"** as follows:

e. ~~Diabetic equipment and supplies~~ DME rebate agreements. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior

approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

ITEM 5. Rescind and reserve paragraph **78.28(1)"b."**

ITEM 6. Amend paragraph **78.28(1)"k"** as follows:

k. ~~Diabetic equipment and supplies~~ DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5)*"e."*

ITEM 7. Amend paragraph **78.28(7)"b"** as follows:

b. Preprocedure review ~~by the IFMC~~ is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval ~~by the IFMC~~ will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by ~~the IFMC and~~ the department. ~~The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.~~

ITEM 8. Amend subrule 78.28(12) as follows:

78.28(12) High-technology radiology procedures.

a. No change.

b. Notwithstanding paragraph 78.28(12)*"a,"* prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

~~(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph 78.28(12)*"e"*); or~~

~~(4)~~ (3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. No change.

d. Required requests for prior approval of radiology procedures must be submitted ~~through the online system operated by the department's contractor for prior approval of high-technology radiology procedures~~ to the department of human services.

e. ~~Services are billed for members with retroactive eligibility.~~

~~(1)~~ When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form ~~470-0829, Request for Prior Authorization~~ 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

~~(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.~~

~~(3) Retroactive authorizations will not be granted when sought for reasons other than a member's retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:~~

~~1. The provider was unaware of the high-technology radiology prior authorization requirement.~~

~~2. The provider was unaware that the member had current Medicaid eligibility or coverage.~~

~~3. The provider forgot to complete the required prior authorization process.~~

ITEM 9. Amend paragraph **79.8(1)"a"** as follows:

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using Form ~~470-0829, Request for Prior Authorization~~ 470-5595, Outpatient Prior Authorization Request, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior

Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

ITEM 10. Amend subrule 79.8(3) as follows:

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial of prescription drugs will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d).

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/30/20.